FRAMEWORK FOR BUDGETARY PLANNING AND CONTROL IN NAVAL HOSPITALS

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Bachelor of Science

The George Washington University, 1968

A Thesis Submitted to the School of Government and Business Administration of The George Washington University in Partial Fulfillment of the Requirements for the Degree of Master of Business Administration

June, 1968

Thesis directed by

Leon Gintzig, Ph.D.

Professor of Hospital Administration

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Leon Slotsky, Ph.D.

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PREFACE

Although a standard budgetary planning and control system is not feasible or desirable for all naval hospitals, the similarity of their functional mission requirements and organizational structure are conducive to establishment of a uniform conceptual framework of budgetary planning and control to facilitate the efficient allocation and management of fund resources.

There is the risk that the absence of standardization reduces a conceptual exploration of this type to a pedestrian effort -- a window shopping expedition looking at budgetary planning and control procedures. Therefore, to temper this risk, where appropriate, this paper emphasizes the reasons for certain procedures relative to the design and implementation of what is hoped will be a flexible and responsive budgetary system. In general, details are included to provide a clearer understanding of procedures rather than to establish a single method of accomplishment.

Following the Introduction, Chapters II and III discuss the functions and organization of naval hospitals with the objective of familiarizing the reader with the basic requirements imposed on naval hospitals. Chapters IV through VI set forth the framework for a system of budgetary planning and control with emphasis on the face-to-face

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interaction of the hospital program managers and the financial and advisory staff, responsibility accounting, and meaningful performance reports and analyses.

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CHAPTER I

INTRODUCTION

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Faced with ever-increasing demands for new and expanded services, a shortage of medical and paramedical personnel, and the fact that hospital costs are rising at a rate higher than those of other services, naval hospital administrators are aware of the need for effective resources management. But costs continue to rise and can be attributed, to some extent, to factors beyond the control of the hospitals. These external influences include:

1. Inflation, population, and utilization
2. Personnel and usages
3. Educational costs
4. Investment in assets
5. Rising measures of progress

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1. Inflation, population, and utilization
2. Personnel and wages
3. Educational costs
4. Investment in assets
5. Rising measures of progress

6. Increase in drug costs -- also expansion in the number and kinds of drugs.[1]

In an effort to improve resources management, measurable progress has been made in naval hospitals in the refinement of the accounting processes, data mechanization, and organizational improvement studies; however, only a limited effort has been directed to the area of budgetary planning and control. Thus it is possible that improvements in the administrative areas have often been dissipated due to the absence of a uniform framework for planning and budgeting.

The purpose of this paper is to examine the budgetary planning and control techniques that are available to naval hospitals for the purpose of allocating and managing fund resources, safeguarding assets, improving operational efficiency, and providing management with the information necessary to make rational decisions.

It is based on the premise that an effective budgetary planning and control process should embrace the meaningful application of the concepts of participative financial planning, timely and accurate reporting, and responsibility accounting.

This paper does not presume to prescribe or advocate a standard budgetary system. The variety and complexity of

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local requirements precludes the establishment of a single system which would be responsive to the management needs of all naval hospitals. It does suggest that naval hospitals, large and small, should function within a single conceptual framework of budgetary planning and control which emphasizes and encourages the active participation of hospital managers in the selection and authorization of plans and programs, the preparation and refinement of budgets, and the execution of financial plans.

Accordingly, report formats for budget estimates, fund allocations, performance analyses, etc. have been omitted on the premise that reports should be constructed in a manner which best meets the needs of local management. It is suggested, however, that local reports should include sufficient data relative to costs and workload to enable local managers and other reviewing officials to make rational decisions in measuring and judging performance.

Research methods used to gather material for analysis included library research, interview, and questionnaire. Library research was directed to existing writings in the fields of hospital organization and management and budgetary planning and control concepts. Interviews were conducted with personnel in the Department of Medicine and Surgery of the Veterans Administration, the Health Care Department of The George Washington University, and the Navy Bureau of Medicine and Surgery. A structured questionnaire, which appears in the Appendix, was prepared and forwarded to twenty-three naval

hospitals in the United States.

It should be noted that interviewees were most generous with their time and assistance. They made information available, shared viewpoints, and stimulated thinking about the application of budgetary planning and control concepts in governmental and nongovernmental hospitals.

The questionnaire survey revealed a wide variety of budgetary techniques currently in use. These variations reflect the procedural differences which are necessary and valuable in responding to local requirements, but more significantly, the techniques reflect the variegated philosophies of budgetary planning and control. These philosophies vary from no participation by program managers in cases where budgets are prepared by the financial and administrative staff, to maximum participation by the program managers.

The completed questionnaires frequently referred to the difficulties encountered in developing and sustaining the active interest of department heads in the preparation and execution of budgets. Admittedly, the success of a participative financial system rests on the cooperation and assistance of all program managers, but it is the contention here that the system itself should be so designed as to generate and maintain active interest by providing the program managers with the financial tools necessary to control their own programs with a high degree of flexibility.

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CHAPTER II

FUNCTIONS OF NAVAL HOSPITALS

In describing the functions of a modern hospital, Dr. M. T. MacEachern said:

> In the light of the broad social responsibility for maintenance and restoring the health of all members of the community, the functions of the modern hospital are essentially four: (a) care of the sick and injured; (b) education of physicians, nurses, and other personnel; (c) public promotion of health; and (d) advancement of research in scientific medicine.[2]

Although military hospitals were established to safeguard the health of a limited strata of society, their fundamental functions differ only in degree from those described by Dr. MacEachern. The functions of military hospitals are: (a) care and treatment of sick and injured military personnel, their dependents, and other authorized personnel; (b) education and instruction of Medical Department personnel; (c) cooperation with civil authorities in matters pertaining to health and sanitation and in the event of disaster and emergencies; and (d) research in medicine and its allied specialties.

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[2]M. T. MacEachern, Hospital Organization and Management, (Chicago: Physicians' Record Company, 1957), p. 29.

CHAPTER II

FUNCTIONS OF MODERN HOSPITALS

In describing the functions of a modern hospital, Dr. A. T. Macbeachern said:

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"Naval Hospital" Defined

The term "naval hospital" has been defined as a fixed medical treatment facility established by order of the Secretary of the Navy, under authorization of Congress, which is primarily intended and appropriately staffed and equipped to provide relatively full diagnostic and therapeutic service in the fields of general medicine and surgery, or in some circumscribed field or fields of restorative medical care, together with bed care, nursing, and dietetic service to patients requiring such care and treatment.[3]

A naval hospital is therefore a complex of varied services and activities. The range of these activities is determined by specific mission requirements which set forth the purpose for which the hospital was established and are stated in broad, general terms.

Mission Requirements

The mission requirements for each naval hospital are set forth in a mission statement which includes the primary mission and, as authorized by the Surgeon General of the Navy, one or more secondary missions. The mission statement represents the continuing functions imposed on a naval hospital and prescribe the parameters within which the hospital will operate.

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[3]U. S. Navy, Bureau of Naval Personnel, Medical Department Publication. Washington, D. C.: U. S. Government Printing Office, 1953, p. 53.

The primary mission of all naval hospitals is:

1. To provide general clinical and hospitilization services for active duty members of the other armed services, dependents of active duty personnel, and other persons authorized in current directives.

2. This mission includes:

   a. The care and treatment of sick and injured military personnel with the objective of their expeditious return to duty.

   b. The prompt disposition of those patients who require special treatment not adequately available or who are found physically unfit for retention in the military service.[4]

The secondary mission requirements are determined on the basis of geographical location, availability of specially trained personnel, and capacity of physical plant.

These secondary missions include:

The instruction of Navy Medical Department personnel, including resident and intern training.

The care and treatment of other than military personnel, such as beneficiaries of the Veterans Administration and other federal and state agencies.

Research in medicine and its allied specialties.

Cooperation with military and civil authorities in matters pertaining to health and sanitation, and in the event of local disasters and emergencies.

The care and treatment of patients in need of specialized, definitive treatment, such as neurosurgery, plastic surgery, or radiation therapy.[5]

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[4]U. S. Navy, Bureau of Medicine and Surgery, Manual of the Medical Department, Washington, D. C., U. S. Government Printing Office, p. 11-1.

[5]U. S. Navy, Medical Department Orientation, p. 64.

The primary mission of all naval hospitals is:

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[5] U. S. Navy, Medical Department Orientation, p. 14.

Adjunct and Supporting Functions

The primary function of a naval hospital is the care and treatment of sick and injured military personnel. But to support this function requires an array of adjunct and supporting services some of which are only tangentially related to the health care field.

The adjunct services include all the diagnostic and therapeutic services required to support the highest standards in the care and treatment of diseases and conditions. These services include the departments of dentistry, radiology, clinical laboratory, pharmacy, occupational therapy, physical therapy, anesthesiology, electrocardiography, and electroencephalography.

The supporting functions vary with the size of the hospital, but essentially include all services necessary to support the health and comfort of patients and to facilitate their treatment and convalescence. This includes the business and administrative departments, such as personnel, fiscal and supply, food service, housekeeping and laundry, recreation services, patient records, and data processing; and the exchange services which include retail sales stores, shoe repair facilities, cafeterias and barber shops.

Primary and Supporting Functions

The primary function of a naval hospital is the care and treatment of sick and injured military personnel. To support this function requires an array of primary and supporting services some of which are only tangentially related to the health care field.

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Summary

Naval hospitals function within the framework of prescribed primary and secondary mission responsibilities. The primary responsibility is the provision of the highest professional standards in the care and treatment of sick and injured military personnel. The secondary responsibilities, while subordinate to the primary, contribute both directly and indirectly to safeguarding the health of the Navy and Marine Corps through research and education, and to the nation through a cooperative effort in responding to health and sanitation dangers and civil disasters.

SUMMARY

Naval hospitals function within the framework of prescribed primary and secondary mission responsibilities. The primary responsibility is the provision of the highest professional standards in the care and treatment of sick and injured military personnel. The secondary responsibilities, while subordinate to the primary, concentrate particularly and indirectly to safeguarding the health of the Navy and Marine Corps through research and education, and to the nation through a cooperative effort in responding to health and sanitation dangers and civil disasters.

CHAPTER III

NAVAL HOSPITAL ORGANIZATION

Within the Navy, a naval hospital constitutes a staff agency in which the care and treatment of military personnel represents the hospital's internal line function and all other supporting or secondary functions, such as personnel and supply, represent the internal staff functions. Thus, the organization of naval hospitals represents a functional division of effort in accordance with the concept of line and staff organization.

The value of line and staff organization in naval hospitals is the fact that each line official in the clinical services reports to only one superior, yet receives advice and assistance from staff officials in the administrative services who have specialized backgrounds, training, and experience not directly related to patient care.

The basic organization plan for naval hospitals provides for the office of the commanding officer, boards, committees, and special assistants, the professional services, and administrative divisions as set forth in Figure 2-1.

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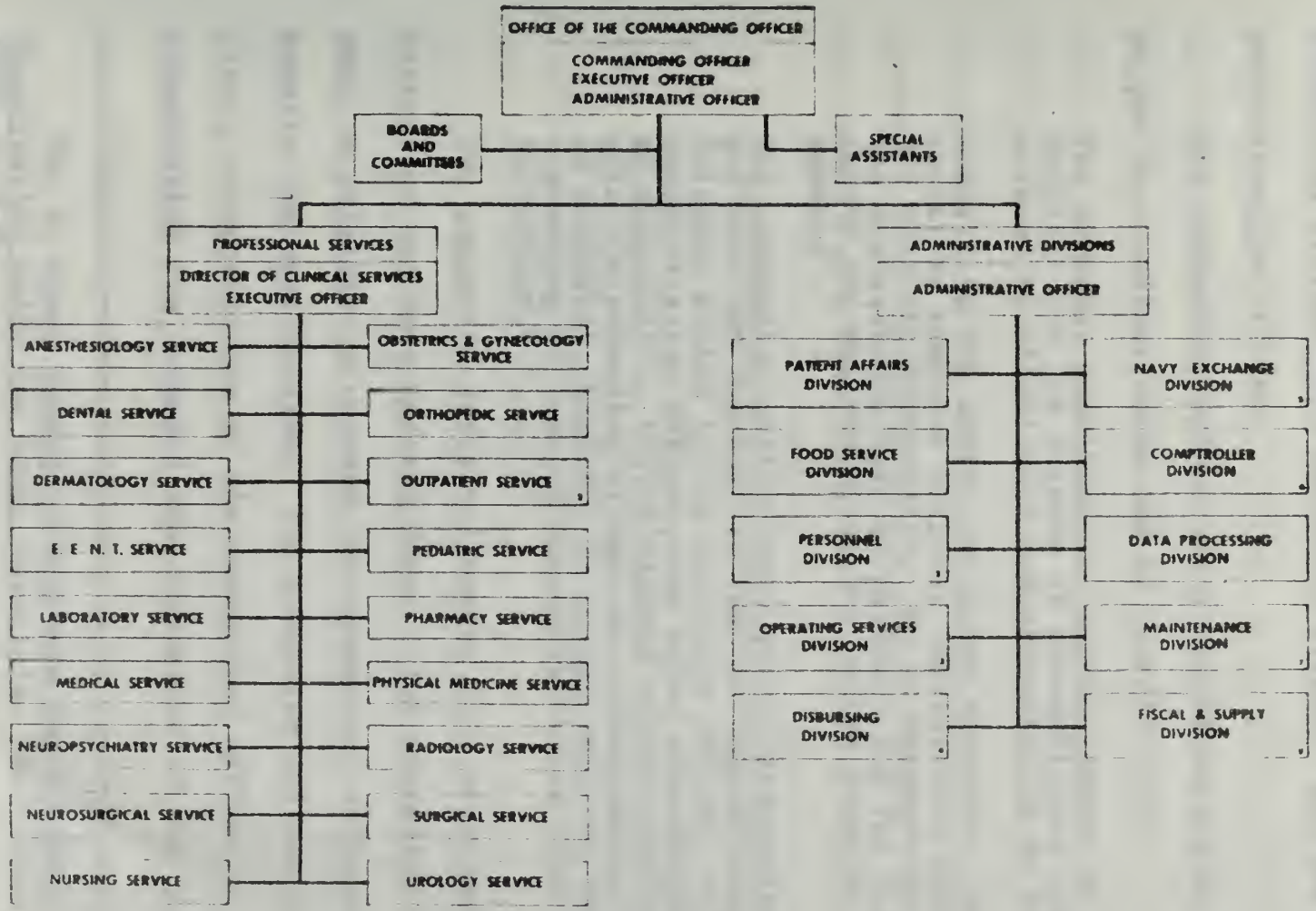
BASIC ORGANIZATION CHART FOR NAVAL HOSPITALS



Office of the Commanding Officer

The office of the commanding officer includes the commanding officer, the executive officer, and the administrative officer.

The commanding officer is a physician and an officer of the Navy Medical Corps and is charged with:

> The command, organization, and management of the hospital for the purpose of accomplishing its mission as effectively and economically as possible.
>
> Subject to the orders of higher authority, he exercises complete military jurisdiction within the hospital reservation. He is responsible for the professional care of patients and for the safety and well-being of the entire hospital command . . .
>
> The commanding officer may, at his discretion and when not contrary to law and regulations, delegate duties to the executive officer, the administrative officer, and other subordinates, as appropriate, to the maximum extent consistent with the retention of control. Such delegation of authority, however, in no way relieves the commanding officer of responsibilities inherent in command.[6]

The executive officer likewise is a physician and an officer of the Navy Medical Corps. The executive officer must be eligible to succeed the commanding officer and is usually the next in rank. The executive officer is the direct representative of the commanding officer in coordinating the internal administration of the hospital.

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[6]U. S. Navy, Bureau of Medicine and Surgery, Organization Guide for Naval Hospitals, Washington, D. C., 1963, p. B-2.

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[6]U. S. Navy, Bureau of Medicine and Surgery, Organization Guide for Naval Hospitals, Washington, D. C., 1953, p. 3-2.

In addition:

> as director of the professional services, the executive officer assists the commanding officer in coordinating the hospital's professional functions and programs. He may, when so designated, serve as chief of one of the hospital's professional services as well.[7]

The administrative officer is an officer of the Navy Medical Service Corps who advises and assists the commanding officer and the executive officer in administering the nonprofessional functions of the hospital. The administrative officer is directly responsible to the executive officer for the coordination and efficient operation of the administrative divisions and for the management improvement functions within the hospital.[8]

Boards, Committees, and Special Assistants

> Various boards, committees, and special assistants may be appointed by the commanding officer to meet requirements for hospital accreditation, to conform to requirements of law or regulations, and to advise the commanding officer on matters of policy or particular interest.[9]

The boards and committees may include a planning board, budget advisory committee, medical records committee, tumor board, medical library committee, and hospital infections committee.

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[7]Ibid., p. B-3.

[8]Ibid.,

[9]U. S. Navy, Medical Department Orientation, p. 65.

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[7] Ibid., p. 1-3.

[8] Ibid.

[9] U. S. Navy, Medical Department Organization, p. 63.

The special assistants to the commanding officer may include a chaplain, a representative of the American Red Cross, a public affairs officer, and when authorized, a comptroller. Only a few naval hospitals have implemented the comptroller concept to date. Technical guidance and assistance in financial matters is provided in most naval hospitals by a fiscal officer who serves as the Chief of the Fiscal and Supply Division and who reports to the commanding officer through the administrative officer and the executive officer.

Professional Services

The Organization Guide for Naval Hospitals provides for the establishment of certain clinical services in each naval hospital. However, the number and designations of these services may be determined by the commanding officer in consideration of the size and character of the patient load. For example, a separate urology service may be established if the patient load requires it or it may be established as a branch of the surgical service.

The chiefs of the professional services are all officers of the Navy Medical Corps except the chief of the dental service who is an officer of the Dental Corps; the chief of nursing service who is an officer of the Nurse Corps; and the chief of the pharmacy service who is an officer of the

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Medical Service Corps.[10]

Each professional service is an organizationally independent entity, reporting directly to the executive officer for coordination control. The services have the following functions in common:

> To maintain the highest standards of professional practice.
>
> To inform the executive officer in matters concerning patients, especially the seriously and critically ill.
>
> To provide consultants when requested, and to collaborate with other clinical services and the administrative divisions to promote optimum patient comfort and speedy recovery.
>
> To exercise general administrative control over wards and supporting facilities assigned to the service; to initiate and conduct research and clinical studies, as appropriate; to participate in or conduct appropriate portions of the hospital training program; to ensure the proper use of supplies and equipment; to prepare reports and prescribed records; and to ensure prompt and proper disposition of patients.[11]

Administrative Divisions

The administrative divisions in naval hospitals are charged with the responsibility for transacting the hospital's business and conducting its administrative functions. The chiefs of the administrative divisions are all officers of the Navy Medical Service Corps except the chiefs of the disbursing and navy exchange divisions who are officers of the

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[10]U. S. Navy, Organization Guide for Naval Hospitals, p. C-1.

[11]U. S. Navy, Medical Department Orientation, p. 69-71.

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[10] U. S. Navy, Organization Guide for Naval Hospitals, p. C-1.

[11] U. S. Navy, Medical Department Publication, p. 19-71.

Supply Corps, and the chief of the public works division, who is an officer of the Civil Engineer Corps when that position is authorized.[12]

The chiefs of the administrative divisions report directly to the administrative officer and are responsible for the effective and efficient performance of their respective division functions.

The chiefs of the administrative divisions have the following functions in common in addition to the specific functions relative to their specialty.

> Plan, direct, and supervise the work and training of assigned personnel.
>
> Prepare and maintain accurate functional organization charts and position descriptions, document the organizational breakdown and the assignment of personnel to positions and duties, and prepare and keep current procedure guides for each billet.
>
> Insure the proper security, custody, use, conservation, maintenance, expenditures, and current inventory of all property charged to the division; and require the economical use of utilities and supplies.
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> Insure that required reports and returns are prepared and submitted in accordance with current instructions and that prescribed records are both current and accurate.[13]

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[12]U. S. Navy, Organization Guide for Naval Hospitals, p. D-1.

[13]U. S. Navy, Bureau of Medicine and Surgery, Manual of the Medical Department. (Washington, D. C.: U. S. Government Printing Office.), p. 11-13.

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[12] U. S. Navy. Organization Guide for naval hospitals, p. D-1.

[13] U. S. Navy, Bureau of Medicine and Surgery, Manual of the Medical Department. (Washington, D. C.: U. S. Government Printing Office.), p. 11-13.

Organization for Budgeting

The ultimate responsibility for the budgeting effort in naval hospitals rests with the commanding officer. When naval hospitals were small and their services limited, the commanding officer could actively participate in the formulation of the budget, but the complexities of modern hospitals in which the full range of care and services is provided as well as extensive programs in research and education, require that budgeting responsibilities be assigned downward. To facilitate maximum usage and control of funds, this downward movement of responsibility can best be accomplished by the allocation of resources by programs and operating organizations.

The programs and operating organizations in naval hospitals are under the cognizance of the chiefs of the professional services and the chiefs of the administrative divisions, who are the program managers for their respective program elements. These program elements comprise the total effort to accomplish a given program. These program elements include salaries, wages, supplies, equipment, and contractual services to accomplish the hospital programs, such as Medical, Surgical, and Food Service.

The downward movement of budgetary responsibility results in a division of responsibility among the program managers, the comptroller or fiscal officer, and the budget advisory committee.

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The downward movement of budgetary responsibility results in a division of responsibility among the program managers, the comptroller or fiscal officer, and the budget advisory committee.

The program managers, having authority and responsibility for their respective programs, for quality standards, and for output schedules, should be responsible for forecasting raw estimates for their programs and justifying budgetary requirements to the commanding officer.

The fiscal officer prepares the recommended budget procedures and schedules, provides procedural and analytical assistance to the program managers, and analyzes, reviews, assembles and coordinates the presentation of the hospital budget to the budget advisory committee and the commanding officer.[14]

The budget advisory committee is responsible for reviewing the fiscal officer's analyses and recommendations and for making necessary recommendations to the commanding officer. The budget advisory committee is usually comprised of senior department heads representing a cross-section of the professional and administrative services. The number may vary with the size of the hospital and the scope of activity; however, it is important that the members be experienced in budget policies and planning. As the director of the clinical services, the executive officer usually serves as the chairman of the budget committee. The fiscal officer should serve as the principal advisor to

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[14]U. S. Navy, Bureau of Naval Personnel, Financial Management in the Navy, (Washington, D. C.: 1962) p. 72.

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Summary

The line and staff organization in effect within naval hospitals provides the optimum organization for the most effective fulfillment of the patient care role. The line structure, through the professional services, provides a functional assignment of authority, responsibility and accountability for the accomplishment of the primary mission. The staff organization, through the administrative divisions, provides the necessary functional specialization to assist and enhance the line effort.[15]

The organization for budgeting in naval hospitals should reflect a division of effort among the program managers, the fiscal officer, and a budget advisory committee with strong emphasis on program manager participation in the development of a sound budget package.

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CHAPTER IV

THE PLANNING AND BUDGETING PROCESS

The fact that the Navy Bureau of Medicine and Surgery (BUMED) does not prescribe standard budgetary procedures for naval hospitals provides each naval hospital with maximum flexibility to develop a budgetary system which is most responsive to local requirements. Specific budgetary guidance relative to format and content is provided by BUMED on an annual basis and broad guidance is provided in the BUMED Financial Management Handbook, which states in part:

> Estimates submitted should reflect the considered planning efforts of responsible program managers or target holders blended into the overall estimates of the activity. Likewise, estimates should represent realistic appraisal of requirements in terms of resource allocation. Concurrence of the budget advisory council, planning board, or some other advisory group and the commanding officer are fundamental to budgetary development and submission.[16]

Due to the diversity of size and the scope of activity, budgeting in naval hospitals should not be constrained by a standard budgetary system. Locally

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[1]U. S. Navy, Financial Management Handbook, (p. 1-3-1).

designed systems, however, can and should embrace all the interrelated services and divisions within the hospital through active face-to-face participation by the program managers. Effective utilization of the program managers' knowledge in the accomplishment of program objectives can facilitate a comprehensive planning and budgeting system.

Allen Schick said, "In the context of budgeting, planning involves the determination of objectives, the evaluation of alternative courses of action, and the authorization of programs."[17] The budgeting process in naval hospitals should provide for the fulfillment of the planning function through the formulation and coordination of the annual budget in a manner which facilitates the total integration of the planning and budgeting effort to achieve an effective instrument for progress and change.

An integrated planning and budgeting process which is dynamic in nature and progressive in direction can best be achieved through the active participation of the hospital managers, the development of flexible budget guidelines, the establishment of realistic and attainable qualitative and quantitative objectives, and the creative application of forecasting methodology.

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[17]Allen Schick, "The Road to PPB: The Stages of Budget Reform", Public Administration Review, XXVI (December, 1966), p. 244.

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Participative Budgeting

Dr. MacEachern suggested the importance of participative budgeting when he said:

> In preparing the budget it is suggested that it is important to realize that the department heads will evidence much more interest in future plans if they have an active part in formulating them. The first benefit to be obtained from budget operation is found in this procedure, since it immediately puts the department heads' minds to work on the financial aspects of the operation of their own unit, and makes them feel responsible for good results. If the laundry manager has participated in financial planning for his department and has committed himself to fulfilling his responsibilities within the framework of specified salary and supply costs, he can be expected to bend every effort toward management of his department within these limitations.[18]

When the commanding officer of a naval hospital delegates to the chiefs of services and divisions the responsibility for efficient and economical operation of the hospital programs, there is an administrative accountability requirement that flows in the reverse order. The primary responsibility of the program manager is to insure that the highest standards of professional and administrative practices are maintained, but he must also insure that he has the necessary manpower, material, and fund resources to support these standards. This can best be accomplished through a meaningful participative budget process.

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[18] Jacobsen, Hospital Organization and Management, (p. 200.)

In a recent survey, naval hospitals currently using the program manager concept were requested to indicate the degree of participation exercised by the program managers in budget preparation. The replies indicated that many hospitals do not seriously consider participative budgeting productive on the premise that estimates provided by the program managers often cannot be accepted as valid due to bias and unrealistic forecasts.

It would seem that the use of the program manager concept without the participative element must necessarily emphasize the "control" aspect -- the budget execution phase. Accordingly, program managers are held administratively accountable to insure that their programs conform to a budgetary plan but they are not given the opportunity to determine their own destiny by participating in the preparation of that plan. If program managers have only limited opportunity to participate in the preparation of the budget they will feel less concerned with the efficient and effective use of resources with frequent unplanned demands as the consequence.

A basic management concern in hospitals is the physicians lack of affiliation with the organization and management of the hospital, and it is suggested that one technique to facilitate management awareness can be active participation in the financial planning process. Significantly, 93 percent of the naval hospital administrative

officers responding to the above mentioned survey indicated that a participative financial system does enhance organizational identity.

An active interest in the budget process however, cannot be taken for granted in the hospital environment -- interest must be stimulated initially and thereafter reinforced by means of financial briefings and reports.

In a participative system, program managers should be provided a thorough orientation by the fiscal officer relative to the local budgetary planning and control procedures. In the absence of a standardized budgetary system, the complexity and style of local systems and procedures are tailored to best meet the needs of the individual hospital. The initial orientation can thus provide the opportunity to familiarize new department heads with the appropriate reports and procedures and to establish rapport and communication between the new program manager and the financial staff.

Subsequent financial briefings for program managers should be conducted by the fiscal officer both individually as necessary and collectively on a monthly basis. The monthly briefings can provide a useful platform for the fiscal officer in which to present oral situational reports relative to the progressive accomplishment of the hospital financial objectives, the development of cost and/or workload patterns as appropriate, and policy and procedural changes.

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The tone and direction of these briefings should emphasize the very real need for the program managers to become involved in the financial management of their own programs and to encourage an active participative effort in the budget process.

It is recognized that participative budgeting will not result in immediate and dramatic attitude changes toward fund limitations and controls and administrative and budgetary constraints. Admittedly, participants will indulge in strategies to obtain larger and larger shares of the budget and budget estimates will not always be acceptable. But it must be recognized that a good budget package cannot be developed by the hospital financial and advisory staff alone. The most significant functions of the fiscal officer and the budget advisory committee should be to weigh the competing claims against limited funds, measure optimistic forecasts against capacity and capability, and most important, provide the instruments of communication for understanding and cooperation between the command and the program managers concerning budgetary policies and requirements.

Thus, providing program managers with the opportunity to participate in financial decisions concerning their own programs can be an effective method of overcoming negative attitudes relating to the value of the budget process and facilitate meaningful progress in obtaining constructive

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Thus, providing program managers with the opportunity to participate in financial decisions concerning their own programs can be an effective method of overcoming negative attitudes relating to the value of the budget process and facilitate meaningful progress in obtaining constructive

cooperation and assistance in the financial management of the hospital.[19]

Budget Guidelines

Basic budget guidelines for naval hospitals are issued by the Bureau of Medicine and Surgery in its annual "Call for Estimates." These broad guidelines establish the general requirements for the form and content of the hospital budget estimates. The detailed guidelines for local budget preparation are subject to individual hospital procedures and should vary with the scope of local requirements.

In general, local guidelines should communicate the command policy decisions, assumptions, and instructions to guide the program managers in the preparation of their raw budget estimates.

The specific budget guidelines applicable to a particular hospital should be prepared by the fiscal officer and forwarded to the commanding officer for review, approval, and issuance to the program managers. These guidelines should reflect the following considerations:

1. Clearly defined budget and planning requirements.
2. Statement as to how budgets are to be prepared and

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how to translate assigned objectives and programs into raw estimates.

3. An estimate of the projected population to be supported.

4. The probable impact of proposed or pending legislation.

5. Realistic and specific deadline dates for submission of adequately supported budget estimates.

Budget guidelines should not impose undue restrictions on program managers. Insofar as possible, budget economies should be encouraged through the creation of an organizational atmosphere which is conducive to self-imposed restraints. Use of such statements as, "expenditure estimates for the budget year will not exceed the current year funding levels" should be avoided as they establish fixed-funding ceilings and tend to reduce the incentive to refine or purify existing programs.

Qualitative and Quantitative Objectives

A mission statement represents the continuing requirements imposed on naval hospitals and prescribes the parameters within which a hospital will function. Mission statements indicate what the hospitals were designed to accomplish, but they do not explain how the accomplishments will be achieved.

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The "real world" mission accomplishment should be reflected in definitive short-term and long-term qualitative and quantitative objectives designed to support the capability of the hospital to discharge its socio-legal obligations and to maintain fiscal responsibility in the control and expenditure of public funds. The objectives envisioned are dynamic in nature and provide the framework for preparing plans, formulating budgets, and if susceptible to quantitative measurement, providing control standards against which performance can be measured. These objectives should represent specific, measurable goals -- expressed in such terms as quantity, quality, time, frequency, ratio, percentage, cost -- which are to be achieved within a stated period of time, long-term and short-term.[20] When properly constructed, the hospital objectives should represent a composite of the individual departmental objectives -- the subdividing process that represents the "hierarchy of objectives" and which reflect the hospital goals expressed in terms of policy and program decisions.[21]

Planning Data

The Program activities within a naval hospital can, for the most part, be measured in terms of performance

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[20]Herman Limberg, Blueprint for a Management Information System, Unpublished paper.

[21]William H. Newman, Charles E. Summer and E. Kirby Warren, The Process of Management, (Englewood Cliffs: Prentice-Hall, Inc., 1967), p. 468.

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indicators (workload factors), which represent the output measurements resulting from expenditure of time, effort, and money. Current performance indicators as prescribed in the BUMED Financial Management Handbook are set forth below. These factors can be averaged and serve as the basis for preparing financial plans and evaluating financial performance.

Medical Records Administration - total patient admissions and total patient discharges for the period concerned.

Inpatient Care Support - includes the operation of central sterile supply facilities and hospital linen requirements -- total occupied bed days for the period concerned excluding the bassinet days accrued while the mother is also a patient.

Clinical Services - total occupied days within the appropriate professional services for the period concerned.

Radiology Services - total services rendered for the period concerned.

Laboratory Service - total unweighted laboratory tests for the period concerned.

Clinical Functions - total outpatient visits and limited services for the period concerned.

Dietetic Service - total number of rations served for the period concerned.

Laundry Service - Number of pounds, dry weight, processed for the period concerned.

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Clinical Services - total manhours with the appropriate professional services for the period concerned.

Radiology Services - total services rendered for the period concerned.

Laboratory Service - total accomplished laboratory tests for the period concerned.

Clinical Functions - total outpatient visits and limited services for the period concerned.

Dietetic Service - total number of rations served for the period concerned.

Laundry Service - number of pounds, dry weight, processed for the period concerned.

Administrative Support - the relationship between administrative support functions and professional services is expressed by the total costs for administration as a percentage of the total costs for the professional services.[22] Costs for the administrative support functions in naval hospitals represent managed costs, the level of which can be largely controlled but for which the optimum relationship between output and input cannot be determined.[23]

Forecasts

The budgeted performance indicators are future oriented and represent a prediction of what will occur; therefore, their reliability is largely predicated on the ability of the fiscal officer to forecast future trends. The ability to forecast the future with any degree of accuracy is limited and requires the creative application of forecasting methodology combined with sound judgment to bridge the gap between the present and the future. The mechanical extrapolation of historical data, with no reflection of command decisions and judgment, contributes only chaos to the planning process.[24] But experience data

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[22]U. S. Navy, Financial Management Handbook, p. I-3-3.

[23]R. N. Anthony, John Dearden, and R. F. Vancil, Management Control Systems, "Notes on Managed Costs", R. N. Anthony, (Homewood, Illinois: Richard D. Irwin, Inc., 1965.) p. 172.

[24]R. N. Anthony, Planning and Control Systems: A Framework for Analysis, (Boston: Harvard University Press, 1965), p. 58.

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can be judiciously applied, and it can frequently warn the fiscal officer of pitfalls which may have substantial cost consequences. Arthur Smithies said, "a knowledge of the past is necessary not only to provide experience analogous to those of the present but to point to methods of improving on past experience."[25]

One technique in the use of historical data is described by Taylor and Nelson:

> Historical data for past periods should be gathered first and the data should be plotted on graph paper in either or both of two ways. The first way is an arithmetic presentation on ordinary graph paper. The second method is a combination of arithmetic (for time periods) and geometric (for units) presentations on semilogarithmic graph paper. This second graph presentation portrays the growth trend line (as a percentage of the preceding period) which demonstrates the growth of the activity.[26]

By using this method, the performance indicators can be forecast on a monthly basis by extending the trend lines to reflect the normal growth pattern for the budget year.

Based upon his analyses, the fiscal officer should furnish program managers with the proposed quantitative program objectives for the budget year expressed in terms of performance indicators (units of service/workload); the results of procedural and management analyses, such as correlations between inpatient/outpatient census with

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[25]Arthur Smithies, Program Budgeting, "Conceptual Framework For The Program Budget", ed. David Novick, (Boston: Harvard University Press, 1965), p. 47.

[26]P. Taylor and B. O. Nelson, Management Accounting for Hospitals, (Philadelphia: W. B. Saunders Company, 1964), p. 148.

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Based upon his analyses, the fiscal officer should furnish program managers with the proposed quantitative program objectives for the budget year expressed in terms of performance indicators (units of service,workload); the results of procedural and management analyses, such as correlations between inputs/costs/expenditures compared with

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[26] Taylor and H. W. Nelson, Improvement Accounting for Hospitals, (Philadelphia: W. B. Saunders Company, 1964), p. 148.

staffing requirements; mathematical models and numerical computations to aid in establishing relationships between projected workload and costs, including data relative to performance variances for the current year; and the historical impact of seasonal variations on workload.

It is not suggested that program managers be furnished with volumes of analytical data relative to workload which may or may not be significant in determining the workload estimates. But sufficient data should be provided in a logical format to permit a program manager to evaluate effectively the methodology employed in arriving at the estimates and their validity for planning purposes. The program manager's concurrence in the program objectives is fundamental to his final acceptance of the budget package as a plan to facilitate the achievement of reasonable objectives rather than as a constraint mechanism imposed by the financial staff.

Equipment Program

In addition to providing planning data relative to workload, the fiscal officer should also furnish program managers with the budget year segment of the equipment replacement program for review, concurrence, and assignment of priorities. At this time, he should also provide the guidelines necessary for requesting new items of equipment for the budget year.

The schedule of the expected life of hospital equipment published by the American Hospital Association is useful in planning replacement of the more durable and/or nontechnical equipment. Technological and scientific advances however, often accelerate obsolescence of technical and scientific equipment necessitating replacement without regard to age or condition. For this reason, equipment programs must provide a measure of flexibility and capacity if the hospital is to adapt to rapid and unpredic able technological and scientific changes. One such approach is to develop long-range and short-range programs.

The long-range equipment program would include the durable type items whose features and functions are relatively unchanging in nature, such as hospital furniture and furnishings, and items required for modernization, such as the basic radiological equipment. The short-range program would provide a medium for expressing the current budget year requirements for demands resulting from changes in techniques or procedures and from technological advances.

Dynamic equipment programs should be developed on a multi-year basis for those categories of equipment for which long-range planning is suitable, but a rigid program of this type is not entirely feasible in the hospital setting. Programs must provide sufficient flexibility to accomodate changing demands and to insure progress in maintaining the highest standards of patient care.

Program Manager Submissions

After reviewing the forecasts developed by the fiscal officer and considering the command assumptions, program managers should establish the program objectives for the budget year. The establishment of program objectives gives the program manager the opportunity to determine his own standards of performance. If he agrees with the forecasts submitted by the fiscal officer, this phase may involve only a validation of the fiscal officer's action. Conversely, he may desire to establish specific objectives for accomplishment during the budget year which may influence the projected level of performance. These program objectives should be expressed in terms of their probable qualitative and quantitative impact on departmental activities.

Quantitative objectives should reflect their influence on the performance indicators as developed by the fiscal officer and the expectations arising from the command guidelines. These objectives may include a percentage increase or decrease in the current services provided, the addition of new services, and a percentage increase or decrease in productivity due to a change in methods or procedures, and would require an adjustment (increase or decrease) in the performance forecasts.

Program Objective Formulation

After reviewing the forecasts developed by the fiscal officer and considering the command assumptions, program managers should establish the program objectives for the budget year. The establishment of program objectives gives the program manager the opportunity to determine his own standards of performance. If he agrees with the forecasts submitted by the fiscal officer, this phase may involve only a validation of the fiscal officer's action. Conversely, he may desire to establish specific objectives for accomplishment during the budget year which may influence the projected level of performance. These program objectives should be expressed in terms of their probable qualitative and quantitative impact on discretionary activities.

Quantitative objectives should reflect their influence on the performance indicators as developed by the fiscal officer and the expectations arising from the command guidelines. These objectives may include a percentage increase or decrease in the current services provided, the addition of new services, and a percentage increase or decrease in productivity due to a change in methods or procedures, and would require an adjustment (increase or decrease) in the performance measure.

Qualitative objectives may include short-term management improvement objectives, proposed consolidation actions to improve services or to conserve resources, expansion of existing services, and relocation of services when necessary to improve utilization of facilities. They may also include the shifting of emphases of existing programs, such as developing community relations programs or improving the quality of supervisory leadership programs.[27]

Thus the qualitative and quantitative objectives should reflect the program managers' decisions in planning the most efficient and economical programs as intermediate goals for accomplishing the mission of the hospital.

In addition, program managers should provide information relating to civilian personnel requirements, unusual nonrecurring expenses which can be anticipated for the budget year, and departmental equipment requirements.

Civilian Personnel Requirements

The ceiling allowances for civilian personnel in naval hospitals are prescribed by the Navy Bureau of Medicine and Surgery; however, within these allowances the individual hospital has considerable flexibility relative to grade structure and grade level. These grade structures and levels are largely determined on the basis of supervisory

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responsibilities and organizational relationships, which are all, to some degree, under the control of the program managers. For example, any proposed organizational changes during the budget year should consider the impact of such changes on employee organizational responsibilities and relationships. Even modest organizational changes can result in increased or decreased responsibilities for the affected positions with an accompanying increase or decrease in grade level. Also, scientific and technological innovations can have a significant impact on the professional requirements of existing positions with resultant budgetary implications.

A review of civilian personnel requirements during the budget preparation phase is an excellent opportunity for program managers to critically evaluate departmental staffing requirements in conjunction with the personnel officer. Deficiencies and imbalances can be corrected more easily if they have been considered in depth during the budget phase in terms of the financial resources required to fund any corrective action.

Nonrecurring Requirements

The normal operating expenses for salaries and wages, supplies, and contractual services can be forecast by the fiscal officer on the basis of his analyses of historical data and in consideration of inflationary factors and established program changes. Nonrecurring requirements,

however, must be anticipated by the program managers and submitted to the fiscal officer for inclusion in the budget. These requirements may include additional items of supply not previously used, travel requirements for training purposes or for attendance at professional meetings, unusual maintenance or conversion of equipment requirements, and additional contractual service requirements such as expansion of clinical laboratory testing services or the need for additional consultants and lecturers. To facilitate quantification of these requirements in monetary terms, the program managers should provide the foregoing data in terms of units of service or other appropriate measures to permit a reasonable projection of additional resource requirements.

Equipment Requirements

To complete the program submission, the program manager must review the budget segment of the multi-year equipment program, assign priorities in accordance with the urgency of need, and develop and submit additional capital equipment projects not included in the current year program. Only those items of equipment with an initial cost of $200 or more or aggregations of similar items of equipment costing in excess of $200 should be included in the equipment program. Equipment requirements costing less than $200 should be included under normal operating expenses, and if such requirements can be anticipated, included in the nonrecurring requirements.

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A critical review of the equipment program by the program managers is essential to insure that the very limited equipment funds are utilized to maximum advantage. The budget year segment of the equipment program may include requirements for which no current demand exists or for which the emphasis has changed and substitutions may be necessary. For example, in the replacement of autoclaves, a multi-year program may include steam autoclaves projected for replacement several years ago and for which it may be now desirable to substitute gas autoclaves. Further, refurbishment or conversion of furnishings and equipment may extend their useful life and thus permit deferral of replacements to later years, releasing the use of current funds for more urgent new or replacement requirements.

Equipment ceilings or other limitations should not be imposed during the budget preparation stage although fund limitations may subsequently preclude the inclusion of all equipment requests in the current budget. The inclusion of all program requests regardless of cost permits effective consideration of alternatives during the review process and permits the most efficient allocation of limited funds among competing claims. If fund limitations subsequently require the deferral of equipment requests, such deferral can be accomplished on a priority basis and the deferred items added to the multi-year equipment program. All requests, however, must receive meaningful consideration during the review process to assure the program managers that their effort is not an exercise in futility.

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Summary

The effective accomplishment of an integrated planning and budgeting process in naval hospitals would be enhanced by the active interest and cooperation of the program managers. The end result of the planning and budgeting process should reflect the cooperative effort of the hospital command, the financial staff, and the program managers.

The hospital budget guidelines provide the framework within which the budgetary estimates are developed. The planning data developed by the fiscal officer and his staff complement the guidelines by quantifying the input and output measurements. Submissions made by program managers insure the comprehensive consideration of all relevant qualitative and quantitative factors and facilitate the efficient and effective accomplishment of a hospital's objectives.

It is suggested that meaningful cooperation and participation by the program managers can be achieved through proper orientation and periodic briefings relative to budget policies and plans, and the projection of the budget to all levels of the hospital as a dynamic tool for more effective management.

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CHAPTER V

BUDGET REVIEW, COORDINATION AND APPROVAL

Before being submitted to the Bureau of Medicine and Surgery for final approval, a hospital budget should be subject to several reviews.

Initially, the program managers should review their requirements during the preparation stage for conformance with the hospital budget guidelines and to insure that their requirements represent a realistic appraisal of resources required to accomplish their program objectives.

Secondly, the fiscal officer and his staff should review and assemble the budget proposals, coordinate requirements with the program managers, and prepare the hospital budget package.

Next, the budget advisory committee should consider the analyses and recommendations prepared by the fiscal officer and conduct hearings as necessary with the program managers.

Lastly, the commanding officer should review and consider the more significant management aspects of the budget, indicate his approval of the budget as the hospitals financial plan for the year, and forward it to the Bureau of Medicine and Surgery for final approval and authorization of funds.

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Fiscal Officer Review

Upon receipt of the program manager submissions, the fiscal officer must translate the program objectives into financial terms to the extent feasible. This review stage encompasses the translation of civilian personnel requirements from man years to salaries, wages and benefits, the review and evaluation of equipment requests, the quantification of recurring and nonrecurring operational supplies and services, the conduct of cost and feasibility studies to insure that duplications do not exist and that the budget reflects a realistic appraisal of requirements in terms of resource allocation, and the integration of the total submissions into a single budget package.

Payroll Estimates.

The civilian personnel requirements submitted by each program manager will be expressed in terms of either the number of personnel or man years required to accomplish the program objectives, and the fiscal staff must translate these requirements into salaries, wages and benefits.

Salaries and wages are based upon standard schedules published by the U. S. Civil Service Commission for grades and grade levels of personnel currently employed, for proposed position changes during the budget year, and for the in-grade increases for high quality performance. Costs for civilian personnel benefits include such items as the

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hospital's contribution for retirement purposes and social security and for uniform allowances.

Equipment Requests.

In reviewing and processing equipment requests, the fiscal officer must obtain appropriate cost estimates which include all relevant installation costs. In particular, the fiscal officer must insure that all present and future cost implications are clearly detailed. Budget proposals often reflect only the immediate or more favorable cost factors without consideration of related or future costs. For example, some considerations in the equipment program might be:

1. Are qualified personnel available to operate the equipment?

2. What are the training costs?

3. Is space available, or will the equipment require structural alterations?

4. What are the operational costs other than personnel?

5. Is there equipment available to perform the same function?

In this connection, Taylor and Nelson describe the problem of capital expenditures in hospitals as:

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1. Are qualified personnel available to operate the equipment?
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> such factors as the needs of the patients, availability of equipment at other hospitals to meet community emergencies and whether existing equipment will suffice. Nevertheless, the hospital should also consider the effect of the use of the new equipment on hospital operations, that is, the income it will produce and the expenses it will require.[28]

Operational Supplies and Services

The quantification of recurring supplies and services can be accomplished by applying cost standards to those output factors susceptible to unit cost measurement, for example, prescriptions and clinical laboratory and radiological procedures. Extreme care should be exercised in the application of standards, however, since they are generally valid only for the short-run. The very rapid rising measures of progress, the increase in costs for medical and surgical supplies, and the expansion in the number and kinds of drugs dictate that current standard costs be viewed with some skepticism when estimating future costs.

Nevertheless, standard unit costs can provide a benchmark from which the fiscal officer can make a reasonably valid estimation of future costs by utilizing adjustment factors which will reflect historical costs and inflationary trends.

Supplies and services for those areas which may be termed "managed costs" and which are not susceptible to unit measurement, as for example, administrative functions,

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Cost and Feasibility Studies

The cost and feasibility studies conducted during the fiscal officer's review should reflect a comprehensive analysis of all relevant costs associated with the program manager submissions.

In consolidating total hospital costs, cost studies should be conducted to insure that costs are coordinated and consistent and that any imbalances are eliminated. The feasibility studies should answer the questions, "How is it currently done?", "What is the proposed method?", and "What are the advantages and disadvantages?"

Feasibility studies need not be formal reports, but they should be conducted in sufficient detail to enable local reviewing officials to objectively evaluate budget proposals and to make rational choices with full consideration of present and future expenditure implications. Comprehensive cost and feasibility studies can also provide the analytical background for understanding the full costs of first-year financing and thus prevent "foot-in-the-door financing" which can be costly to a hospital.[29]

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[29]Werner Z. Hirsch, Public Administrative Review, "Toward Federal Program Budgeting", XXVI (December, 1966), p. 261.

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The Budget Package.

As a final step, the fiscal officer must integrate the total program manager submissions into a single budget package for the hospital as a whole. Performance indicators should be expressed in terms of unit costs based upon the standards developed through the analysis of historical costs adjusted as necessary for inflationary factors and known program changes, and the projected cost per patient day should be developed by fiscal quarter for the benefit of reviewing officials.

At this juncture, the fiscal officer should present the proposed budget package to the program managers for review.

Changes and adjustments to the budget submissions should be discussed in detail with the program managers and their concurrence obtained. It should be emphasized that the fiscal officer provides a staff service to the hospital in applying his expertise to the development of a financially sound and flexible budget. He may question the desired delivery schedules or completion dates of equipment or projects; he may raise questions of coordination, inconsistency, or feasibility but he may not question requirements. The determination of requirements is a line function; therefore, the line official, with the advice and assistance of the fiscal officer should make the final decision as to what is required to accomplish the program objectives.

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Changes and adjustments in the refinement of the budget package are frequently necessary, but they must not destroy the identity of the original program manager submissions. The fiscal officer must insure that any adjustments to the original submissions are based on objective budgetary or financial management considerations, and, if possible, discuss them with the affected manager prior to the adjustment. It is essential that the program managers accept the budget and be willing to abide by its provisions; therefore, they must consider the individual budget program as the product of their judgment and decisions and the standard against which they will be willing to measure their performance during the budget year.

The fiscal officer's budget review should reflect completed staff action and the budget, at this point, should represent a unity of effort for the achievement of the hospital mission and objectives.

Budget Advisory Committee Review

Following review by the fiscal officer, the budget should be submitted to the budget advisory committee. As an attachment to the budget, the fiscal officer should include a memorandum outlining its principle features, the objectives to be accomplished, and explanations of increases and decreases in proposed expenditures. In addition, he should furnish the committee with analytical data used in

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Budget Advisory Committee Duties

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determing program requirements and the results of cost and feasibility studies with appropriate recommendations.

The functions of the budget advisory committee are to review the fiscal officer's analyses and recommendations, insure that requirements are neither too conservative nor too optimistic, conduct hearings with the program managers relative to departmental requirements, cause revisions to be made as appropriate, and submit a report to the commanding officer outlining recommendations and offering alternative courses of action as necessary to achieve a balanced program.

It is suggested that the budget advisory committee can best serve the hospital if it considers all budgetary requirements. A recent survey of naval hospitals indicated that only 50 percent of the budget committees in the respondent hospitals actually reviewed the total budget. The remaining 50 percent limited this phase of budget review to specific cost elements, such as supplies only, equipment only, minor construction and alterations, or civilian pay.

The budget advisory committee review provides the first opportunity for a critical evaluation by line officials of program objectives and their correlation with mission requirements. The budget advisory committee should conduct scheduled hearings with the program managers for the purpose of measuring the cost/benefit ratios of program objectives, questioning requirements as appropriate, and

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After its hearings with the program managers, the budget advisory committee can then consider the trade-off questions in the level of program aggregates and imbalances can be resolved for the most efficient budget mix. The budget committee should now attempt to answer the question, "Would an extra dollar be more wisely spent for program A or for program B?" Weidenbaum says that this is the fundamental question in the allocation of budgetary funds and that "raising these questions should not be taken as expressing value judgments, but rather as indicating a pattern for decision making."[30]

Trade-off considerations, however, should not be used to justify the arbitrary reduction or curtailment of one program for the benefit of another unless there is a positive net advantage to the hospital.

Obvious imbalances in programs can be resolved by mutual agreement between the program manager and the budget committee. Program manager proposals which are defensible but which cannot be resolved during the budget hearings should be included in the committee's report to the commanding officer with appropriate recommendations.

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Commanding Officer Review

Action by the commanding officer represents the final review stage at the hospital level.

The commanding officer reviews the budget to determine conformance with the budget guidelines as promulgated by the Bureau of Medicine and Surgery and the hospital, to measure the long-range effect of program proposals, and to review summary programs totals and other management aspects of major significance.[31] He also considers and resolves program manager reclamas (requests for restoration of funds) which may be submitted as the result of actions or recommendations of the budget committee.

Recommendations or actions of the budget committee may be unfavorable or unacceptable to a program manager and he may desire to submit a reclama for the consideration of the commanding officer. All necessary advice and assistance in the preparation of reclamas should be provided to the program managers by the fiscal officer, but he must also be prepared to make specific and objective recommendations to the commanding officer for the satisfactory resolution of the matter in question.

Following the review and approval by the commanding officer, the budget along with supporting papers is forwarded to the Bureau of Medicine and Surgery for mark-up, approval, and authorization of funds.

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[31]U. S. Navy, Financial Management in the Navy, p. 74.

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Bureau of Medicine and Surgery Review

The Bureau of Medicine and Surgery review of a hospital budget is conducted on a program manager basis. The various segments are reviewed and evaluated by the cognizant Bureau program managers who make recommendations consistent with the Bureau's guidelines and objectives.

Upon final approval at the Bureau level, the individual hospitals are issued fund authorizations in the approved amounts, which contain the authority to incur and make expenditures in the accomplishment of the approved programs.

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Summary

The hospital budget must be a comprehensive master plan if it is to serve as an effective tool of management. The several budget review stages can enhance the achievement of this budgetary range and depth through the active participation of program managers in determining program objectives and the resources necessary to accomplish those objectives, followed by successive stages of review and refinement by the fiscal officer, the budget advisory committee, and the commanding officer.

The fiscal officer must conduct necessary cost analyses and feasibility studies to insure that budget proposals are feasible within capacity and time and economically defensible, that priorities are properly assigned, and that the final budget represents a unified management effort for the most efficient and effective fulfillment of the hospital's mission. The budget advisory committee provides a platform for full and fair budget hearings and the objective consideration of competing claims on fund resources. The commanding officer reviews the more significant management aspects of the budget and evaluates it as the financial expression of the underlying plans and objectives.

A comprehensive budget review thus facilitates internal coordination for the development of a dynamic budget package which will reflect the decisions and judgment of management and be responsive to any unpredictable demands imposed by mission requirements.

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CHAPTER VI

BUDGET EXECUTION

In the preceding chapters, an integrated process of planning and budgeting in naval hospitals was described as including the determination of objectives, the preparation of a budgetary plan to accomplish those objectives, estimation of the costs for the budget year, presentation of the budget document for review and analysis at the various levels of local responsibility, and submission of the budget to the Bureau of Medicine and Surgery for review, approval, and authorization of funds.

Budget execution encompasses all actions associated with the accomplishment of the approved budgetary plan. It is the process by which administrative and financial techniques are used to achieve the most effective, efficient, and economical use of public monies in pursuit of the hospital's plans and objectives. Fundamental to this approach is the application of the concept of responsibility accounting through the classification of controllable and noncontrollable costs in a manner that provides a useful basis for analysis, and a timely reporting system to facilitate performance analysis for the correction of spending inefficiencies or for adjustments due to fluctuating demands.

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BUDGET EXECUTION

In the preceding chapters, an integrated process of planning and budgeting in naval hospitals was described as including the determination of objectives, the preparation of a budgetary plan to accomplish those objectives, estimation of the costs for the budget year, presentation of the budget document for review and analysis at the various levels of local responsibility, and submission of the budget to the Bureau of Medicine and Surgery for review, approval, and authorization of funds.

Budget execution encompasses all actions associated with the accomplishment of the approved budgetary plan. It is the process by which administrative and financial techniques are used to achieve the most effective, efficient, and economical use of public monies in pursuit of the hospital's plans and objectives. Fundamental to this approach is the application of the concept of responsibility accounting through the classification of controllable and noncontrollable costs in a manner that provides a useful basis for analysis, and a timely reporting system to facilitate performance analysis for the correction of opening inefficiencies or for adjustments due to fluctuating demands.

Procedures to accomplish the budget execution phase will differ in degree and method between one hospital and another, but the basic process should provide for the development of a sound financial plan by major programs, the allocation of funds on a controllable and noncontrollable basis, and a meaningful budget reporting system to monitor program performance.

Financial Plan

Upon receipt of the approved budget from the Bureau of Medicine and Surgery, the fiscal officer prepares the annual financial plan for the hospital.

If the budget has been approved as requested, the allocation of funds to the program managers can be made immediately. The approved budget may not include all the funds requested however, and adjustments must therefore be made to spread the reductions to the affected programs. These reductions should be accomplished through the cooperative effort of the fiscal officer, the budget advisory committee, and the program managers.

The fiscal officer's responsibility at this time is to analyze the approved budget and determine those programs affected by the reductions and their probable effect on the ability of the hospital to accomplish its mission. This analysis should be prepared in the form of a financial position statement to the commanding officer by way of the budget advisory committee and should contain recommendations relative to the actions necessary to reduce the total

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requirements to the approved level. These recommendations may include:

1. A priority listing of new and replacement equipment items which may be deferred.

2. Nonrecurring program elements that can be reduced or deferred.

3. Cost reduction actions which can be taken to reduce expenditures.

4. Potential reductions in current program elements.

5. Recommendations relative to the submission of a reclama to higher authority for recoupment of all or a portion of the budget reduction.

Upon receipt of the fiscal officer's recommendations, the budget advisory committee should conduct hearings with the appropriate program managers to solicit their advice and assistance in isolating those requirements which could be reduced or deferred without impairing the accomplishment of the program objectives. Usually, the curtailment of programs due to fund limitations is viewed with considerable concern by the program managers; therefore, it is important during the review process that the managers be assured that their budget programs will not be dissipated through arbitrary budget cutting decisions. Full and fair hearings can be effectively used to communicate the hospital's financial position, elicit voluntary program reductions, provide full consideration of the program manager's presentations and justifications, and facilitate a rational decision process

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1. A priority listing of new and replacement equipment items which may be deferred.

2. Nonessential program elements that can be reduced or deferred.

3. Cost reduction actions which can be taken to reduce expenditures.

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in the allocation of funds.

Accordingly, these hearings should not provide the rationale for the justification of arbitrary reductions in funds by the budget committee. The program managers should be given the opportunity to determine the specific program element capable of being reduced without destroying the viability of their programs. Self-imposed fund reductions will usually generate greater concern in the expenditure of funds during the performance phase.

The process of adjusting budgets to available funds is generally a painful process. Frequently, hearings will not produce sufficient reductions to remain within the approved budget without creating severe dissatisfaction and discontent. In this event, the budget advisory committee, with the advice and assistance of the fiscal officer, should develop alternative courses of action with appropriate recommendations for presentation to the commanding officer for consideration. These recommendations may include the deferral or adjustment of budgeted items or a reclama to the Bureau of Medicine and Surgery for the restoration of funds.

Allocation of Funds

Program activities in naval hospitals may be considered in terms of responsibility centers. That is, inputs are measured in terms of costs incurred and outputs are defined

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as units of services provided and the relationships between the two can be calculated. In allocating the programs funds in terms of cost inputs, a distinction must be made between controllable and noncontrollable costs.

Although all costs are controllable by someone, the program manager may have only limited control of certain costs, and as Peirce said, "nothing confuses budget operations more than the charging of costs over which the supervisor has no control, unless such items are set out separately and labeled."[32] Conversely, if too many cost elements are categorized as noncontrollable, the program managers are unable to develop a meaningful awareness of the total costs associated with their programs.

In the survey conducted in connection with this study, naval hospitals were asked to indicate the categories of cost for which program managers are held locally responsible. The following responses were received:

Cost Category	Percentage
Supplies	100
Civilian salaries and benefits	7
Military pay	0
Contractual services	23
Maintenance and repair, furniture, furnishings and equipment	30

It can be argued that the assignment of responsibility for certain costs does not necessarily relate to the

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categorization of controllable and noncontrollable costs. Nevertheless, the absence of accountability indicates, for example, that the program managers cannot influence the civilian and military payroll costs associated with their programs and these very substantial cost elements are, therefore, nonassignable or noncontrollable. This approach presupposes that all programs are functioning with the minimum number of personnel required and that program managers are utilizing their personnel in the most effective and productive manner. This supposition is convenient, but it is of questionable validity when it is considered that payroll costs constitute approximately 70 percent of the total costs in the operation of a naval hospital.

In reality, if the planning and budgeting process reflects a comprehensive determination of resource requirements, civilian salaries and benefits will be subject to less fluctuation than other expense elements, other than fixed annual contracts, due to civilian personnel ceilings and mandatory wage schedules.

It has been previously suggested that costs for such program elements as salaries and benefits be considered as "programmed" costs and allocated and reported to the program managers on that basis rather than as controllable or noncontrollable. The merit of this approach is that it circumvents the apparent reluctance to consider such costs as controllable and encourages the allocation of total costs.

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Terminology should not be the criterion, however, for determining the cost elements to be allocated to the program managers. Program managers should be given the opportunity to control all possible costs associated with their respective programs and for which they can exercise some degree of influence in the level of expenditures.

Responsibility accounting should be more than the token assignment of relatively minor cost elements. The importance of responsibility and accountability is diminished if a program manager is held accountable for $1,000 in supplies but relieved of accountability for $100,000 in payroll costs.

Following the determination of controllable and noncontrollable or "programmed" costs, funds should be allocated to the program managers on a quarterly basis and divided into program element, such as salaries, equipment, supplies, contractual services, etc. The allocation document should explain any program variations and set forth the procurement schedule for any capital equipment items. In addition, a monthly breakdown of projected workload data should be furnished to establish the criteria against which the end results of the expenditure of time, effort, and money will be measured.

Technology should not be the criterion, however, for determining the cost elements to be allocated to the program managers. Program managers should be given the opportunity to control all possible costs associated with their respective programs and for which they can exercise some degree of influence in the level of expenditures.

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Funds Control

In the execution of the budgetary plan, it is desirable that the day-to-day obligation and expenditure actions of the program managers be as relatively free of central control as possible. Federal hospitals, however, must operate within the framework of a multitude of laws and regulations which establish the legal criteria for the expenditure of public monies. Action documents which obligate a naval hospital for the payment of goods and services must, therefore, be reviewed to insure compliance with the applicable laws or regulations.

This legal review implies a system of pre-audit by the financial staff of the hospital. It must be emphasized, however, that any system of pre-audit should be conducted for the purpose of determining the legality of the action and that the action is consistent with the approved financial plan, but not for the purpose of exercising centralized control of day-to-day requirements or quantities.

U. S. Navy Regulations state, in part, that a department head shall "control the expenditure of funds allotted, and operate the department within the limits of such funds," further, that he shall "insure economy in the use of public money and stores."[33] While these are administrative and not statutory constraints, nevertheless,

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it is felt that they address themselves equally well to a fundamental premise that an effective program manager system should reflect decentralized financial control of day-to-day operations with central control exercised on an exception basis through a summary performance analysis reporting system.

Performance Reporting System

The concepts of participative budgeting and responsibility accounting are two aspects of budgetary planning and control, but no planning and control system will be effective or complete without prompt and accurate feedback of performance results.[34] The third side of the triangle is a timely performance analysis reporting system.

A timely and accurate reporting system is essential to facilitate action to correct spending inefficiencies and to initiate action promptly if more serious consequences are to be avoided. Reports which are made too frequently, however, often reflect only minor or negative changes and may negate the effectiveness of the reporting system as a control device since they will become routine and will be filed without adequate analysis. The frequency of the performance analysis reports should, therefore, be determined on the basis of the manager's need to know. Programs that are very active, such as the pharmacy and the surgical

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Performance Reporting Issues

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services, may require bi-weekly reports, whereas other departments may require only monthly reports.

Timeliness and accuracy are important features of a reporting system, but perhaps of more significance, performance analysis reports must be meaningful to the program managers.

Reports submitted to higher authorities are generally expressed in accounting terms such as the accounts involved or the cost accounting codes and, therefore, mean very little to the program managers within the hospital. The program manager is interested in what he did and how well he did it and he desires to obtain this information without time-consuming translation of accounting language and symbols. For this reason, it may be necessary to construct the local performance analysis reports outside the regular accounting records and reports; however, data mechanization greatly facilitates this process and neither destroys the identity of the original accounting data nor imposes undue reporting requirements on the fiscal and accounting office.

Performance analysis reports should be provided in sufficient detail by program element to permit the program manager to make a realistic appraisal of his performance and to conduct a meaningful analysis of the variances. For weekly or bi-weekly reporting, the report should reflect the total funds budgeted for the quarter, the funds budgeted to date; the actual costs to date, and the cost variances. For monthly reporting, the report should reflect, in addition to

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the foregoing cost data, the budgeted workload, the actual workload to date, the workload variances, and data relative to the prior year costs and workload to date.

It is significant that 85 percent of the naval hospitals responding to the recent survey currently do not include workload data in local performance reports. It is suggested that this analytical information can be quite useful for the program managers in determing the causes of budget variances and to facilitate the preparation of comments and explanations.

In essence, local performance reports should provide sufficient data toppermit a timely and meaningful analysis of the current year budgeted to actual costs and workload from which the program manager can effectively exercise cost control.

Variance Analysis

Perhaps the greatest problem in naval hospitals is determining appropriate standards of performance. What should the program managers be held accountable for?

In establishing standards or benchmarks for variance computation, Bonini, et al, listed three possible standards and the one that appears most applicable to naval hospitals is described as a "standard created by the establishment of the initial plan for the current period, embodied in the

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plan and reflecting the expected environment."[35] The expected environment in naval hospitals is developed during the budgetary planning process and is based on forecasting the internal and external forces that will determine the level of activity for the budget year. But planning is never static and until man develops the ability to foretell the future variations in expected to actual will occur.

The preparation of budgets and the reporting of variances do not control costs. Rather, it is the hospital's use of variances that determines the value of the budget system and, to a great extent, the attitudes and reactions of the program managers to the entire budget process. Admittedly, there has to be some credence in the fact that a plan means something, but as Anthony said, "conformance to plans is not the standard against which performance should be measured. The closer the better is not necessarily the best rule."[36]

Variance analysis must not be used as a "witch hunt" technique to extract conformance, but rather as a management control device to encourage self-apprasal by the program managers, to identify the need for improvement, and to guide future actions. In this sense, the budget is viewed as an evaluation standard rather than a pressure device.

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Reprogramming

When variances do occur, the program managers should not be required to solve their problems in a vacuum. The fiscal officer should provide the necessary advice and assistance to facilitate changes in cost patterns or, if variances cannot be corrected to avoid recurrence, to prepare a petition to the commanding officer, by way of the budget advisory council, for a budget revision.

It is frequently necessary to revise the original financial plan due to variations in cost patterns, workload, or mission requirements. If budget flexibility permits, these revisions can often be accomplished by reprogramming budgeted requirements, but they may require recourse to the Bureau of Medicine and Surgery for the additional funds. In either case, revisions to the original budget should proceed on the same basis as the initial budget preparation.

In consultation with the affected program managers, the fiscal officer should prepare the reprogramming documents for review and approval by the budget advisory committee and the commanding officer. Budget reprogramming actions, however, should be limited to those of a substantial nature such as a marked increase in patient services or census and minor program element adjustments accomplished within the program if possible.

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Fiscal Officer's Analysis

In addition to the variance analyses conducted by the program managers, the fiscal officer should conduct an analysis of the total hospital performance and submit a monthly financial briefing report to the commanding officer through the budget advisory council.

The fiscal officer's analysis can best be accomplished on an exception basis through the establishment of acceptable budget variances and thus obviate the necessity for detailed analysis of relatively minor variances.

The survey of naval hospitals indicated that 55 percent of the respondents consider a 3-5 percent variance as acceptable, 20 percent indicated that 10 percent was an acceptable level, and 25 percent indicated that no acceptable variance has been established. One hospital stated that all variances are examined for cause and postulated that short-term variances are meaningless -- only long-term averages have probable meaning.

It is recognized that short-term variances can be distorted, for example, by supply or purchase actions occurring on the final cut-off date for the performance report; however, these deviations become apparent early in the process of analysis and do offer plausible explanations for the variances. It is felt that analysis of all variances tends to make the analytical process a time-consuming mechanical procedure and frequently entails the pursuit of insignificant departures from the plan. Variance analysis

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should be a useful management control device and not a routinized clerical procedure.

An alternate procedure in variance analysis is the selection of strategic control points to facilitate the timely preparation of the monthly financial position report. The strategic control points should be selected on the basis of how directly or indirectly they effect the total operation of the hospital.[38] Such control points may include the pharmacy, operating room, clinical laboratory, and the central sterile supply room. Unfavorable variances at these points can serve as indicators to signal the requirement for more detailed analysis.

The output of performance analysis is the variances that may occur in the budgeted to actual performance and serve as useful inputs for a high degree of control in the effective and efficient management of the hospital. In addition to their value for the current year, budget variances are useful when appraising inputs to budgets for subsequent years by signalling pitfalls which can have substantial cost consequences and thus may point to methods of improving on past performance.

If properly administered, performance and variance analyses can influence the attitude and behavior of responsible hospital personnel towards greater acceptance of the necessity for budgetary control by creating a favorable

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budget awareness on the part of all managers, improving operating performance, and facilitating budget revisions.

Control and Flexibility

A final word should be said relative to control and flexibility during the budget execution process.

Budget execution must be concerned with cost control considerations to prevent overexpenditure of available funds, but at the same time the process must provide a measure of flexibility to meet changing program conditions.

Control has been defined as the process of binding operating officials to the policies and plans set by their superiors.[39] This definition invites the hazard of overcontrol and can result in budget execution becoming synonymous with "financial control", a term that has acquired the negative connotations of limitation, regulation, domination, master, whip hand, etc. Rather than being restrictive or regulatory, budget execution should expedite the accomplishment of the hospital's plans and objectives. Accordingly, budget execution should be redefined in terms of facilitating rather than controlling the day-to-day operations of the program managers.

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Durand included the element of flexibility in the control process when he said:

> When we say that an operation is controlled, we do not mean that it is kept always exactly to plan; rather we mean that if there is significant departure from plan, the matter is dealt with by some appropriate adjustment.[40]

Budget execution must provide the flexibility to accomodate timely revisions. Budget flexibility can provide the control or restraint necessary to keep operations within the total funds available without imposing an inviolate requirement for rigid conformance to a program element. An inflexible budget tends to stifle the program manager's initiative and will reduce participative budgeting to a distasteful task to be avoided. The participative process permits the program managers to establish reasonable and attainable standards against which their performance will be measured. Thus, the standards encourage the imposition of self-controls to insure a disciplined effort to adhere to the budget or take appropriate action when deviations occur.

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[40]Robert Y. Durand, Business: Its Organization, Management and Responsibilities, (Englewood Cliffs: Prentice-Hall, Inc., 1958), p. 389.

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[40]Robert V. Durand, Business: Its Organization, Management and Responsibilities, (Englewood Cliffs: Prentice-Hall, Inc., 1958), p. 389.

Summary

Budget execution is the dynamic process of achieving the hospital's plans and objectives developed during the planning and budgeting process. The effective and efficient accomplishment of these plans is contingent on the responsible administration of financial and administrative techniques to influence the adherence to plans or to take appropriate corrective action when deviations occur.

The concepts of responsibility accounting, timely and accurate progress reporting, performance and cost analyses and flexible control are considered fundamental in providing the hospital program managers, the financial staff, and the commanding officer with the information necessary to make intelligent decisions in the utilization of funds in the best possible manner.

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CHAPTER VII

CONCLUSION

Scientific and technological changes in the health care field are proceeding at an incredible rate, and in naval hospitals they create constant demands for new services and the expansion of existing ones. The keen competition for resources to fund these demands imposes on the individual naval hospital a heavy responsibility to achieve maximum efficiency in the conservation of assets and minimization of expenses. A comprehensive budgetary planning and control system which reflects an integrated planning and budgeting phase and a dynamic budget execution phase can make a significant contribution to the effective utilization of resources in the fulfillment of the patient care role.

Planning and Budgeting

The planning and budgeting phase should reflect an integrated effort to formulate a comprehensive budget plan for the most efficient, effective, and economical accomplishment of the program objectives which provide contributory or intermediate goals in the attainment of the hospital's mission.

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Planning and Budgeting

The planning and budgeting phase should reflect an integrated effort to formulate a comprehensive budget plan for the most efficient, effective, and economical accomplishment of the program objectives which provide contributory or intermediate goals in the attainment of the hospital's mission.

Participative budgeting -- the active face-to-face interaction between the program managers and the hospital financial and advisory staff -- is fundamental to the development of a budget plan which will represent a realistic appraisal of requirements in terms of resource allocation. Participation in the budget process provides the program manager with an opportunity to formulate his own budget program, an understanding of all facets of the budget process, and a responsibility for the success of his program. Participation is the necessary ingredient in creating a willingness at all levels of the hospital to abide by the budget provisions.

The budget is the financial expression of the underlying plan; therefore, the planning process provides the opportunity for trade-off considerations and for making decisions among alternatives in the selection and authorization of programs. The integration of planning and budgeting permits the consideration of plans and programs on a quantitative and qualitative basis and produces an effective blueprint for the expected level of activity.

Budget Execution

The budget execution phase should be designed to develop and influence the attitudes and behavior of the program managers to substitute cooperation and participation for the negative connotations that the concept of budgetary control has acquired. If the budget is presented solely as

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Budget Execution

The budget execution phase should be designed to devise and influence the attitudes and behavior of the program managers to maximize cooperation and participation for the negative connotations that the concept of budgetary control has acquired. If the budget is presented solely as

a control device, it will be viewed by the program managers as a restrictive covenant and they will dread and shun any budgetary task. Control and flexibility are key issues in the budget execution phase and can best be achieved under the broad umbrella of responsibility accounting -- the allocation of controllable costs to the program managers, the analysis of performance, and the meaningful use of variances; and timely and accurate reporting -- the preparation of meaningful reports to the program managers which can be analyzed without the interpretation of burdensome accounting data.

The effective accomplishment of the missions and objectives of naval hospitals is predicated on management judgment and decisions. Efficient budgetary planning and control procedures can do much to facilitate a rational decision process and to insure successful competition for scarce resources.

Recommendations

The basic purpose of this study has been to examine the general concepts under which naval hospitals allocate and manage fund resources and the extent to which these concepts have been applied. Details were included only to clarify procedures and not to advocate any single method of accomplishment.

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Although the inclusion of specific recommendations relative to budgetary methods and procedures would be inappropriate, nevertheless, because of the diversity of budgetary systems currently in use at naval hospitals, it is felt that there is a compelling need to establish uniformity in the interpretation of concepts. Accordingly, the following recommendations represent the concluding beliefs of this study.

First, the concept of participative planning and budgeting should be centrally defined and promulgated to emphasize its dynamic nature which, in the spirit of helpful cooperation, can contribute significantly to a comprehensive planning and budgeting process for the efficient allocation of fund resources.

Second, responsibility accounting should be redefined in terms of "facilitating" rather than "controlling" the day-to-day operations of the program managers; and this concept should be applied to all costs subject to the control or influence of the program managers and thus assist them in making intelligent decisions about the operations under their cognizance.

Third, performance reports should be provided to the program managers on a timely basis consistent with the level of program activity; and such reports should include relevant workload data to permit a meaningful analysis in the determination of budget variances and in the preparation of comments and explanations.

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APPENDIX

NAVY GRADUATE FINANCIAL MANAGEMENT PROGRAM
THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, D. C.

Dear Sir:

Although there are numerous demands on your time, will you take the several minutes required for a questionnaire that hopefully will result in a comprehensive review of the budgetary planning and control process in naval hospitals?

This study is being conducted for partial fulfillment of the requirements for the degree of Master of Business Administration, Navy Graduate Financial Management Program, The George Washington University. Its intent is to examine the allocation and management of fund resources at naval hospitals within the framework of our existing budgetary planning and control system. Secondly, the study is designed to determine the degree to which the existing system is responsive to effective and efficient resources management in fulfillment of the patient care role.

All naval hospitals are being surveyed and it is expected that answers to the enclosed questionnaire will provide valuable information from which a conceptual framework for budgetary planning and control can be constructed. In this connection, any additional comments that you consider pertinent to this area are respectfully solicited. Comments may be placed either on the reverse of the questionnaire or on a separate sheet.

It should be emphasized that this study is not interested in individuals or specific locale. For this reason individual identification is not required, nor is the questionnaire so structured as to permit any latent identification through deduction.

Accordingly, will you be so kind as to cooperate by completing the attached questionnaire at your earliest convenience and by then returning it in the franked reply envelope provided for your use? In order to complete this study within the prescribed time limitation it is essential that all replies be received prior to 20 December 1967.

Very respectfully,

G. P. KANE
LCDR, MSC, USN

PLEASE CIRCLE OR FILL-IN THE APPROPRIATE RESPONSE(S). ADDITIONAL COMMENTS MAY BE WRITTEN ON THE REVERSE OF THE QUESTIONNAIRE OR ON A SEPARATE SHEET.

Is a program manager/target holder system used? YES NO
IF YES, ANSWER QUESTIONS UNDER SECTIONS A,C, AND D
IF NO, ANSWER QUESTIONS UNDER SECTIONS B,C, AND D

SECTION A. PROGRAM MANAGER/TARGET HOLDER SYSTEM

1. Indicate the categories of cost for which program managers are held locally responsible.

   a. Supplies
   b. Civilian pay and allowances
   c. Military pay
   d. Contractual services
   e. M&R furniture, furnishings, and equipment
   f. All of the above
   g. Other: _____

2. Who forecasts the units of service(performance indicators) for the budget year?

   a. Program managers
   b. Comptroller/fiscal officer
   c. Other: _____

3. Who forecasts the expenditure requirements for the budget year?

   a. Program managers
   b. Comptroller/fiscal officer
   c. Other: _____

4. How frequently are local performance analysis reports provided to the program managers?

   a. Weekly
   b. Bi-weekly
   c. Monthly
   d. Other: _____

5. Do performance analysis reports include the planned to actual workload factors?

   YES NO

6. What is considered an acceptable variance in planned to actual expenditures?

   a. 3%
   b. 5%
   c. 10%
   d. Other: _____

7. Is there an orientation procedure for program managers? YES NO
If yes, briefly outline procedure.

8. What types of financial management information are provided to the program managers for budget preparation? During the budget year? (If a printed form is used, please enclose a copy)

SECTION B. IF A PROGRAM MANAGER SYSTEM IS NOT USED

1. Who forecasts the units of service (performance indicators) for the budget year?

a. Commanding Officer and Administrative Officer
b. Department Head
c. Comptroller/fiscal officer
d. Budget Advisory Council/Planning Board
e. Other:

2. Who forecasts the expenditure requirements for the budget year?

a. Department Head
b. Comptroller/fiscal officer
c. Budget Advisory Council/Planning Board

3. Briefly describe the local procedure for control of expenditures?

SECTION C. THIS SECTION APPLIES TO THE FUNCTIONS OF THE BUDGET ADVISORY COUNCIL OR PLANNING BOARD. THE TERM "BUDGET COMMITTEE" SHOULD BE CONSIDERED SYNONYMOUS WITH THE FUNCTIONAL ORGANIZATION IN USE AT YOUR HOSPITAL.

1. What is the organization for budget review and coordination?

   a. Budget Advisory Council
   b. Planning Board
   c. Other: _____

2. How frequently does the budget committee meet?

   a. Monthly
   b. Quarterly
   c. Other: _____

3. Who is chairman of the budget committee:

   a. Executive Officer
   b. Administrative Officer
   c. Other: _____

4. In what capacity does the comptroller/fiscal officer serve the budget committee?

   a. As advisor
   b. As a member

5. Is the Nursing Service represented on the budget committee? YES NO

6. What budgetary requirements are subject to review by the budget committee?

   a. Supplies
   b. Contractual services
   c. Travel
   d. Equipment
   e. Civilian pay
   f. All of the above
   g. Other: _____

7. Does the budget committee review local performance analysis reports during the budget year? YES NO

8. Does the budget committee conduct hearings with the program managers/department heads relative to reprogramming requirements? YES NO

9. What is the timeframe for the equipment replacement program?

   a. One year
   b. Three years
   c. Five years
   d. Other: _____

10. Does the budget review process permit a realistic appraisal of requirements in terms of resource allocation? YES NO

SECTION D. GENERAL

1. What type of financial management information is provided to the Commanding Officer? (If a printed form is used, please enclose a copy)

2. Who establishes the budget guidelines relative to budget policies and planning?

a. Commanding Officer
b. Comptroller/Fiscal Officer
c. Budget committee
d. Other: _____

3. Is historical workload and cost data maintained on a continuing basis for growth trend purposes? YES NO

4. Are short-run qualitative and quantitative objectives established? (For example, annual management improvement objectives, resource conservation objectives, or increased facility utilization objectives) YES NO

5. Are periodic financial status briefings conducted? YES NO
If yes, please describe type and frequency.

INDICATE YOUR AGREEMENT OR DISAGREEMENT WITH THE FOLLOWING STATEMENTS

6. A rigid requirement to conform to a financial plam tends to stifle initiative to perform below the plan. AGREE DISAGREE

7. The present budget and financial plan is an effective planning and control device. AGREE DISAGREE

8. Program managers have developed a meaningful understanding of the budget as a device for planning, coordinating and controlling day to day operations. AGREE DISAGREE

9. Comptroller/fiscal officers tend to be too strongly influenced by the financial aspects of the problems they consider and should take other factors into consideration as well. AGREE DISAGREE

10. Comptroller/fiscal officers tend to make decisions which satisfy someone, rather than provide optimal solutions. AGREE DISAGREE

11. In the final analysis, budgets control only money. AGREE DISAGREE

12. The comptroller/fiscal officer should not become involved with the planning processes because such involvement tends to commit him to a program in which his objectivity and disinterest are of the most importance. AGREE DISAGREE

13. Because of the new demands which are constantly being made on financial management, the comptroller/fiscal officer must be able to direct his attention into technical and policy areas which have previously belonged only to specialists. AGREE DISAGREE

14. The implication of staff control in the term "budgetary control" discourages the cooperation and participation of program managers/department heads in the budgetary process. AGREE DISAGREE

15. Participative budgeting enhances the medical officer's affiliation with the management of the hospital. AGREE DISAGREE